CCBHC Stakeholder Council
River Place Euclid Ave, Des Moines
March 29, 2016
10AM-3PM
MINUTES

Stakeholders: Teresa Bomhoff; Kelsey Clark (phone); Gayla Harken; Jessica Leonard; Vickie Lewis; Bob Lincoln (phone); Aaron Todd (phone)

General Public: Tim Bedford; Ann Burkhardt; Christina Eggink-Postma; Jayna Fischbach; Mary Lynch (phone); Randy Renner (phone) Christina Schark (phone); Kim Scorza

CCBHC Grant Governance Team: Theresa Armstrong; Laurie Hancock-Muck; Laura Larkin; Julie Maas; Michele Tilotta; Deanna Triplett

Staff: CDD: Caitlin Owens; Ann Riley; IDPH: Janet Nelson; Consortium: DeShauna Jones (phone)

I. Welcome and Introductions

Laura Larkin thanked everyone for joining by phone or in person. She noted that she wanted to start by providing clarification for stakeholders who received a survey from the Consortium. DeShauna Jones explained that SAMHSA requires grantees to collect information on ten indicators about how communities are managing mental health and substance use disorder services. She said stakeholders should have received the survey from her, and she realizes many people likely didn't respond because it didn't seem relevant at this point. She requested that those who have not responded do so before April 15th. Laura added that stakeholders are welcome to share the survey with someone else who might have the information being requested, and since it will be sent quarterly some of the questions with fewer responses now will likely increase as they become more relevant over time.

Laura briefly spoke about the CCBHC selection and certification process. She noted that some things regarding the selection process she won't be able to talk about due to procurement rules and more details about certification would be discussed later on the agenda. She said the grant team is working hard to finish the RFP and it should be released soon. She said the clinics will be selected once the RFP period closes and those clinics will go through the certification process before the demonstration grant application is submitted in the fall. She said they expect to select a minimum of two clinics, but could possibly select up to four.

II. Update on Evidence Based Practices

Julie Maas shared that the grant governance team had originally identified six evidence based practices (EBPs) as part of the grant, but that has been reduced to five due to feasibility of securing training for one of the selected EBPs. She said she would be talking about the three EPBs selected that primarily focus on mental health, and Michele Tilotta would be discussing the two that focus primarily on substance use disorder treatment.

Mental Health Focused Evidence Based Practices

ACT

Julie shared that DHS is planning to offer an "ACT 101" webinar to provide an overview of the ACT service for any interested provider. If a provider is interested in forming a new ACT team this will provide them an overview of what that entails. She said between July and September of this year selected CCBHCs will receive training and technical assistance to either support the development of a new team, or to ensure fidelity of existing teams.

CCBHCs building a new team would commit to receiving technical assistance from the University of Iowa Hospitals and Clinics (UIHC) IMPACT team, which would include a full day on-site meeting with agency staff and community stakeholders, two additional days on-site in the first month, one day on-site each month for one year, and weekly teleconferences as needed. CCBHCs with an existing ACT team would also commit to receive technical assistance from the UIHC IMPACT team, which would include a one or two day on-site fidelity review depending on which fidelity tool is used.

PRA

Julie noted that Psychiatric Rehabilitation Approach is sometimes called Intensive Psychiatric Rehabilitation (IPR) in Iowa, but the Boston Model uses PRA and they are moving towards aligning the terminology in Iowa with the national certifying body. She said there will be a "PRA 101" webinar offered sometime in June to give any interested provider more information on the practice. Between July and September there will be a three day train-the-trainer course and a 60 hour practitioner training.

TF-CBT

Julie shared that there is a free 10-hour introductory webinar available to any interested provider at TFCBT.org, and completion of the webinar is a requirement for anyone enrolled in the two day in-person training that will be offered this summer. After the training therapists must participate in nine follow up technical assistance calls, complete three treatment cases, and pass a knowledge-based test. The technical assistance calls include up to ten clinicians and are typically scheduled either twice a month for six months, or once a month for twelve months.

Julie said more information would be posted on the CCHBC website regarding these trainings soon.

Stakeholder Questions

- At the last meeting we talked about how expensive it is to start an ACT team. Has there been any further thought put into that and whether it will be feasible for providers?
    - Response: There are funds set aside to cover some of the costs during the planning grant, and any selected clinic can build the cost of the training into their prospective payment system (PPS). Particularly with ACT there are a lot of regions looking at developing teams, so it won't necessarily all fall to this grant to develop since there is interest around the state. The figure provided at the last meeting also included the time it would take for the team to become self-sufficient
- Will you address the differences between rural and urban ACT teams in the trainings?
    - Response: Yes, our technical assistance providers at the University of Iowa will address that in detail.
- Will ACT be covered by the MCOs?
    - Response: Yes, it is a Medicaid service and required to be covered.
- Are IPR and PRA the same in practice?
    - Response: IPR is an Iowa specific version of PRA that has some additional requirements added by Magellan.. The state will review the requirements and standards Magellan developed and determine which to carry forward in a more standardized statewide PRA model.
- Can a CCHBC contract with an ACT team that already exists?
    - Response: Yes.

Stakeholder Comments

- Even if there is funding available it is important to be cognizant of what is being expected of providers and how much it will cost, including the other EBPs. Providers will be losing billable hours and will have ongoing costs associated with the sustainability of these practices.
- A lot of the success of this initiative seems to hinge on these EBPs, so how they are implemented is very important.
- IACP and Polk County Health Services is going to do an introduction training for providers on EBPs, and could possibly include the CCBHC team as a partner as well. It will be May 17th at the Iowa State Center. Because this project impacts more than just the selected CCBHCs, we really thought it was important to get people on board with what EBPs are, what practicing to fidelity means, and so on. The trainers will be giving a brief overview of ACT as well, and have been requested to first focus on the six EBPs listed by SAMHSA that are in the mental health redesign legislation.

Substance Use Disorder Focused Evidence Based Practices

FIT

Michele Tilotta shared that Feedback Informed Treatment (FIT) ended up not being feasible to include in the EBPs being offered due to the schedule of the trainer and the intensity of the introductory training, which includes several webinars and a training in Chicago. She said it is a wonderful EBP, and they certainly encourage providers to go forward with it if they are interested. A FIT training has been scheduled in Iowa in November, but seating is limited. She said more information and a link to register can be found at trainingresources.org.

MI

Michele said she has a call scheduled with the Addiction Technology Transfer Center (ATTC) regarding Motivational Interviewing (MI) and Medication Assisted Treatment (MAT) trainings, and more details would be available soon. She said for MI they are looking at an introductory training for those who may be new to the field and an intermediate training for practitioners who already have some familiarity with the model. She said the trainings will likely be one or one-and-a-half days.

MAT

For MAT there will be general education on what it is, and a prescriber component to the training. She said there is currently a lot of research going into the treatment of opiate addiction, and IDPH has a grant to help prescribers get certified to prescribe buprenorphine which they hope to be able to braid with this grant to offer the training to more individuals.

Michele said information about the trainings would be posted on the CCBHC website, and open to all providers, though priority will be given to applicants of the CCBHC grant.

Stakeholder Comments

- A group of providers in Marshalltown were awarded funding through SAMHSA's Project ECHO, which provides mentoring and ongoing support to clinicians to help them build on and expand what they learned in their training. The clinicians who are participating have been very positive about it.

III. Overview of Clinic Criteria

Laura said everyone should have a copy of the clinic criteria, and it can also be found on the DHS CCBHC website and SAMHSA's website. She said searching for "Section 223" would also pull it up.

Laura said the clinic criteria provides useful information on what clinics and states must do during the planning and implementation periods. She said there are the nine required services, the six program requirements, and

behind those are a lot of other requirements and standards. Within the criteria there are certain things SAMHSA gives states latitude to decide, and she will go into further detail about those areas.

Program Requirement #1: Staffing
Laura shared the staffing requirements that will be expected of CCBHCs in Iowa, and whether the service must be provided directly by the CCBHC or if contracting with a designated collaborating organization (DCO) is allowed. Staff that must be hired directly by the CCBHC include a licensed substance use disorder professional, mental health professional and a psychiatrist or prescriber. Staff that can be hired directly or through DCO include a family peer support specialist, a peer support specialist, a peer recovery coach, SUD case managers, and an IHH care coordination team. CCBHC's may be required to directly hire MAT prescribers or through a DCO depending on the final decision IDPH makes on the MAT program.

Cultural competency is mentioned several times throughout the criteria, and part of the requirements will be informed by the needs assessment completed by the state. SAMHSA expects clinics to be customized to serve populations in their area including having night and weekend hours as needed. It is an expectation that cultural competency is reflected in staff training and the overall practices and procedures of the CCBHC.

Laura stated that suicide prevention and response is also mentioned several times in the criteria. Clinics will be expected to provide information on how they will respond to a suicide crisis including follow-up with individuals who have attempted suicide. Additionally, services to veterans is one of the nine required services and clinics will need to look at current practices and staff competencies to determine if staff training on veterans and military culture is necessary.

Michele mentioned that she met with Laurie Raymond from the VA, who is a member of the stakeholder group, and she provided a great overview of veteran services. Michele said she is thinking about asking her to do a webinar on veteran healthcare services including eligibility, services offered, where services can be provided, etc.

Program Requirement #2: Availability and Accessibility of Services
Laura shared that clinics must meet access time frames for routine, urgent, and emergency needs. Based on initial screening and assessment, routine services and initial evaluation must be completed within ten business days, urgent needs within one business day of request, and emergency needs must be appropriately addressed immediately. She said the levels of access are driven by the screening and assessment process and are centered on meeting the needs of individuals seeking services. Clinics must also be available and accessible to anyone, regardless of availability to pay or place of residence. Laura explained that doesn't mean they are expected to provide all services for free, but the expectation is no one is turned away and individuals are connected to crisis services and stabilized before arrangements are made to transition back to their home community.

Additional accessibility standards include providing intake paperwork in languages appropriate to the catchment area and hours of operation that meet the needs of the population being served.

Program Requirement #3: Care Coordination
Laura stated SAMHSA has stressed care coordination as the linchpin of CCHBCs. While all services do not need to be provided within the CCBHC, SAMHSA says it is better for as many services as possible to be provided in-house. In the event of formal agreements for care coordination and other services, it is important that there be a close relationship between the CCBHC and other agencies. Laura shared that the IHH model is the primary method of care coordination in Iowa, including for the purposes of CCBHCs. Iowa has had several discussions with SAMHSA about how the IHH model aligns with the criteria. SAMHSA has repeatedly said they do not want

Iowa to undo their current system but the details are still being worked out. The criteria also mentions coordination and follow-up with individuals after inpatient psychiatric hospitalization.

Program Requirement #4: Scope of Services

Laura stated the nine required services are discussed in this section of the criteria, and again noted whether the CCBHC must provide the service directly or if it can be provided through DCO. CCHBCs must directly provide crisis behavioral health services; screening, assessment, and diagnosis; person and family centered treatment planning; and state designated outpatient mental health and substance use disorder services. Services that can be provided directly or through a DCO are targeted case management; psychiatric rehabilitation services; peer support, peer counseling, and family/caregiver support; and intensive, community-based mental health care for members of the armed forces and veterans.

The criteria states that a CCBHC must provide crisis behavioral health services unless there is a state-sanctioned crisis service system, which in Iowa means an agency that has been contracted to provide crisis services in an MHDS region. Required crisis services are 24-hour mobile crisis, emergency crisis intervention services, crisis stabilization services, ambulatory detox, and suicide crisis response. Laura said there has been a lot of discussion about detox services among states with planning grants, as initially they were talking about residential detox, which caused concern among grantees. Subsequently, SAMHSA revised the requirement and released clarifying guidance which can be found on the CCBHC webpage.

Laura stated there are other states besides Iowa that provide targeted case management (TCM) differently than SAMHSA's model. In addition to serving the populations currently receiving TCM services, CCHBCs will be required to serve people at high risk of suicide and those with a primary substance use disorder diagnosis. The TCM model for individuals with a substance use disorder diagnosis is still being developed and will be specific to CCBHCs since it isn't a population covered by Medicaid. Michele added that DHS and IDPH are trying to develop a common definition for TCM. They have discussed individuals with a failed recovery journey, those who may not have recovery supports in place, individuals with moderate to severe diagnoses, individuals who are homeless or have been incarcerated. She said substance use disorder TCM is a relatively new practice and very few states nationally are currently providing similar services.

Laura reviewed the requirements for peer and family support services and stated that Iowa expects direct peer support services in addition to what is currently required of IHHs. CCBHCs will also be expected to provide peer recovery coaching services, which is not currently formalized under Medicaid. Michele gave a brief history of peer recovery coaching in Iowa. She said it was initially rolled out through IDPH's Access to Recovery Grant and Iowa uses a training curriculum out of Connecticut. She said it has been a very successful initiative and she is looking forward to it being a covered service, as she believes that people with a primary diagnosis of substance use disorder greatly benefit from it. Michele said she has been working with DHS to look at consistency between peer recovery coaching and mental health peer recovery, which was piloted through Magellan.

Laura encouraged stakeholders to review details and requirements for all of the nine required services, which can be found in Section 4 of the criteria document. She mentioned key components of the criteria for screening, assessment, and diagnosis include ensuring practices are culturally competent, and offering primary care screening and monitoring services that include follow-up. She noted that clinics aren't required to provide those primary care services, but similar to what is currently done in IHHs they will be expected to ask some basic screening questions about health risks.

Program Requirement #5: Quality and Other Reporting

Laura said if a state is awarded a demonstration grant they will be working with a national consultant to compare CCBHCs outcomes to traditional services. SAMHSA has developed 32 reporting measures clinics will be required to report on, which can be found in the criteria document. She said of the 32 there are 17 clinic specific measures, and 15 the state would be required to report on. These measures are subject to change pending federal approval.

Program Requirement #6: Organizational Authority, Governance, and Accreditation
Laura pointed out that the criteria requires 51% of a CCBHC's board to be comprised of adults with a mental illness, adults in recovery from substance use disorder, and family members.

Stakeholder Questions

- Will there be funding to provide technical assistance on how to do the PPS and/or what is required for the DCO model, including liability, supervision, electronic health records, etc?
    - Response: SAMHSA has guidance on PPS, and as a reminder there are two types to choose from and Iowa has chosen to do PPS 1. There is grant money set aside for PPS technical assistance, which DHS is considering offering internally but will look into what is available before making a final decision.
- Will there be training provided on cultural competency for selected clinics?
    - Response: Not specifically. It is expected that clinics will address their needs in their application, and when the state completes the needs assessment we will again look at whether there are certain things the clinic could benefit from based on the results.
- Is person/family centered treatment planning only provided with the permission of the patient?
    - Response: Yes, it will follow current rules. Individual and family engagement is a major part of this program, and encouraging family centered care is an important part of that.
- How many mobile crisis units currently operate in Iowa? This could be a limiting factor for CCBHCs.
    - Response: Not sure, but have that information back at DHS and can follow-up. It could be limiting, but it could also help areas who were already thinking about providing the service by formalizing the requirement.
- In addition to specific requirements regarding individuals who are suicidal, what about about aggressive, potentially homicidal behavior?
    - Response: We would expect providers to be responsive to that, and it should be addressed in the person-centered treatment planning and crisis plan.
- When do you expect the application to be released and clinics will be selected?
    - Response: Not sure of the exact release date, and the submission date will be determined by when the application is released. They hope to give applicants as much time as possible to review, write, and submit.
- Will site reviews be part of the application?
    - Response: No, but there is a strong possibility it will be part of the certification process.
- Is the assumption that the number of sites you select will be the number you intend to certify?
    - Response: Yes, we will select clinics we intend to certify.

Stakeholder Comments

- The National Council has a lot of information about CCHBCs, including the criteria, on their website.
- There are a lot of Burmese refugees in the Marshalltown area, as well as individuals from Sudan and Mexico. The Ethnic Minorities of Burma Action and Resource Center (EMBARC) in Des Moines has been offering training and resources on how to address the needs of the Burmese population. This has included competency based training on how individuals can act as translators, and some very specific

work related to health including assistance with translating brochures and materials into multiple languages.
- The Iowa Office of the Attorney General has funds for working with refugees which may be useful to supplement funding.
- The suicide rate among refugees is extremely high.
- Strength-based case management is a good model for continuum of care, and is typically one step down from ACT.

Public Questions/Comments

- Have you looked at how you want to gather information to assess the quality of care, and the long term benefits versus the cost?
    - Response: Part of the measures are looking at whether people are having their needs met. Some of the indicators, like BMI, are pretty straightforward. Others, like suicide assessment and follow-up are more qualitative. Iowa could ask for more measures beyond what is required if that seems necessary. We will be looking primarily at whether people are staying in the community, whether they are successfully completing treatment, etc.

IV. Needs Assessment

Laura started the needs assessment discussion by noting that this was a component of the program that has required a lot of thought; it is mentioned often but the guidance isn't always clear. She said it is a requirement of the certification process, and they have been talking with IDPH about existing needs assessments and asked the stakeholder group to share any assessments done in their areas. The needs assessment will be done by the state, and will look at if the clinic's services are responsive to the needs of the area the CCBHC will serve.

Janet Nelson from IDPH spoke about some prevention specific needs assessments IDPH has conducted. The first assessment Janet discussed was the Tri-Ethnic Community Readiness Survey. She said the survey is easy, inexpensive and a great way to discover community readiness. She said this survey focused on underage binge drinking but the format could easily be adapted for different issues. With the Tri-Ethnic Community Readiness Survey they first conducted six interviews within the community, and she suspects the CCBHC grantees will be surveying similar groups with the possible addition of veterans. One person conducts the survey and it is generally inexpensive and a good way to learn about the community. The interviewer gathers information about several different dimensions including the knowledge of the issue, community effort and knowledge of that effort, leadership, community climate, cause and consequence, and the resources related to the issue. The questions are provided and the specific issue can be plugged in.

After the interviews, there is a consensus scoring component done by at least two people who did not conduct the survey. Finally, there is a community readiness scoring sheet where the information is plugged in.

Janet said an interesting thing about the dimensions is that communities may be at different levels of readiness, so it may be necessary to put together the strategic plan to acknowledge the different levels of the community. She gave the following example: there could be a discrepancy between community knowledge of effort and actual effort being put forth, which is an important piece of knowledge and tells a community where they should focus their efforts. Questions are weighted the final score determines readiness. She noted you have to be careful about who you choose to survey because you don't want someone who is entirely knowledgeable about your program or issue, otherwise your results will be skewed. Michele added that this is considered a model needs assessment by SAMHSA.

Janet said part of the assessment was looking at capacity, level of treatments that were in place, what organizations address behavioral health and other topics. All areas were addressed in the Community Readiness Manual which was frequently referenced by coordinators of the needs assessment. The Manual helps determine who should be represented at the table, what resources are available and missing, and how to address gaps. Janet said one of the strengths of this part of the process is that it keeps people from assuming services and supports are in place that may not be.

Michele asked Janet to share lessons learned from this process or things she would suggest people think about when conducting their own assessment. Janet said if you are going to do the Community Assessment Workbook where you gather data to be sure not to do it in a silo; make sure to reach out to other groups who may have already collected some of the information and/or those who have access to different populations and perspectives. She said by doing this, it also becomes an awareness activity which is important for communities as well. She said the whole process was a learning experience.

Laura said the grant team is trying to understand what is already out there in terms of needs assessments, how they can fit with this grant, and what new data may need to be collected. She noted each clinic will have its own needs assessment conducted on the clinic's catchment area which will likely be a multi-county area. She said the goal is to make sure the clinics are meeting the needs of their entire catchment area.

Laura said going forward she envisions the role of the stakeholder group in the needs assessment will mainly be providing feedback, suggestions on who to contact in the areas the needs assessments will be conducted and any suggestions for resources or other things to consider.

Julie shared examples of other needs assessments that were shared by members of the stakeholder group prior to the meeting. The first assessment was the Polk County Health Chartbook. She said the assessment included some of the counties that surround the Des Moines and West Des Moines metropolitan areas including Dallas, Warren, Madison, and Guthrie. Julie shared a handout with the demographics shared in the Chartbook. They included the population from 1990 all the way through the projected population in 2025. She said this is useful to the CCBHC process because it is important to look to the future when doing the assessment. Laura added that it will be expected for applicants to talk about their areas, who they serve, and make it clear that they are aware of the needs of the community they serve.

The second example shared was the 2015 Central Iowa Capital Crossroads Community Health Needs Assessment conducted by Mercy, Unity Point, and Broadlawns Hospitals. It focused on behavioral health needs and is another example the grant team wanted to share with the stakeholders as examples of information that can be included in a needs assessment.

Laura added there was another needs assessment that was shared with the grant team that was done in Polk County but more qualitative in nature than the other examples. She said in her opinion a needs assessment should include both quantitative and qualitative components in order to fully address the needs for the CCBHC catchment areas. Laura said SAMHSA expects states to conduct robust needs assessments and that they are addressing the gaps identified. She asked if anyone in the group has any other examples of needs assessments to send them to Julie Maas.

Laura reviewed some points from the CCBHC criteria that discuss the needs assessments including the clinic staffing plan, service access forms must be translated in the languages identified and services must be provided at times identified in the assessment.

Stakeholder Questions

- In the case of this grant, we are being chosen, so the focus of the county assessment would be on both substance use disorders and mental health?
    - Response: Yes, and those were both focused on in the assessment workbook. The goal is to get a snapshot of behavioral health in a particular area to see where the gaps and areas of strength are.
- If an entity wants to be a CCBHC, as a part of their application will they have to complete this process?
    - Response: No, after clinics are selected this will be done by the grant team.
- What is the difference between the Behavioral Risk Factor Surveillance System (BRFSS) and other statewide assessments?
    - Response: All available types of data should be used in needs assessments, and the BRFFS data was used while doing the Tri-Ethnic Community Readiness Assessment. Janet said they partnered with local public health departments to share and compare data, which was very useful.
- Do local public health departments collect the same information in the same way, or do they have different priorities they focus on?
    - Response: Not sure, but would think they would be different based on the needs of the county.
- Will peer and family support workers need to be certified through the state or specifically through the IDPH certification discussed?
    - Response: The training requirements for peer support won't be any different than they are now. They won't have to go through the certification necessarily, but they will need to complete the training required. Clinics have to have adult peer support, family peer support, and recovery peer coaching. DHS has a contract with the University of Iowa for peer support training and they have been offering it fairly regularly. Training for peer support, family peer support, and recovery peer coaching are all 40 hours.

Stakeholder Comments

- Nine counties in northwest Iowa have completed a needs assessment to identify the top issues to focus on and include in a strategic plan. Behavioral health always makes the list but has yet to make it into the strategic plan, which could be due to a lack of education on the issue, workforce shortages, or something else.
- It depends on how much a community is talking about behavioral health as well. There is also still a lot of stigma and reluctance to talk about behavioral health issues, especially in rural areas, which could contribute to a community not being ready to address the issue.
- Assessments should ask if people travel outside of the community for treatment or services and why they do so. Is it because they don't want services at a local organization to remain anonymous, or is it because there are long waiting lists? Those are important distinctions.
- We will want to make sure we are working with our local public health offices to make sure we know what data they collect and if they have data or information we can use towards the assessment.
- It sounds like the CCHBC assessment will mainly focus on types of services but it should really go a step further to examine what it will take to actually address the needs identified. I am thinking specifically of workforce, which a lot of people are aware of but think is an issue out of their hands, but it needs to be addressed with everything we have.
- When conducting needs assessments in the past that have generated awareness and community interest, it has been useful to hold a community forum at the end to address the results and build on the awareness generated.

- Hillcrest in Dubuque has a small Opioid treatment program at Mercy/Turning Point that has been up and running since August. They also have therapists certified in Trauma-Focused Cognitive Behavioral Therapy connected with both urban and rural counties.
- MHDS Regions should be working on recruitment packages, which could help address the workforce shortage issue.

Public Questions/Comments

- Will there be an option for the CCBHCs to build recruitment costs into their rates to try to address some of the workforce issues discussed today?
    - Response: Not sure, but will look into that.
- The Rural Iowa Primary Care Loan Repayment Program, which is often underutilized but a great resource that needs to be more widely marketed.

Next Meeting: Thursday, July 28th from 10am-3pm at the West Des Moines Community Schools Community Education Building